

WRITE LEGIBLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: K.C. General Hospital No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 17 days
In this community 37 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2010 E. 9th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME PERRY WRIGHT

3. (b) If veteran, name war No record 3. (c) Social Security No. No record

4. Sex M. 5. Color or race Col. 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife No record 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct. 17th 1880
(Month) (Day) (Year)

8. AGE: Years 60 Months _____ Days 10 If less than one day hr. _____ min.

9. Birthplace Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business
MOTHER FATHER { 12. Name Unknown
13. Birthplace Unknown
14. Maiden name Unknown
15. Birthplace Unknown

16. (a) Informant's own signature Record Clerk
(b) Address Gen. Hospital No. 2

17. (a) Burial (b) Date thereof 10-31-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Municipal Cemetery

18. (a) Signature of funeral director H. A. Johnmeyer
(b) Address City mortician

19. (a) 11-1-40 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 27th
year 1940 hour 102 minute 25 M.

21. I hereby certify that I attended the deceased from 10-10-40, 19____, to 10-27-40, 19____;
that I last saw him alive on 10-27-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death PULMONARY TUBERCULOSIS

Due to _____

Due to _____

Other conditions See above
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. O. Durbin (M. D. or other) _____
Address Supt. Gen. Hospital No. 2 Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.